APPENDIX H

Mental Health Individualized Treatment Plan

Board of Mental Health Individualized Treatment Plan
(Inpatient or Outpatient Provider)

Name of Person: _____

Date of Birth: _____ Social Security Number _____

☐ Initial ☐ Supplemental

To: The Mental Health Board of the _____ Judicial District, _____ County, Nebraska

The above named person is under my care for treatment of _____ _____. As a qualified mental health professional in compliance with Neb. Rev. Stat. § 71-906 , it is my opinion that this person meets diagnostic criteria for the following mental disorder(s) and is in need of treatment as stipulated below:

Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Patient Clinical Information:

1. _____
2. _____
3. _____
4. _____

Current treatment goals and projected timelines to achieve goals (specify inpatient versus non-inpatient treatment goals):

☐ Hospital Treatment Plan Attached

1. _____
2. _____
3. _____
4. _____

Proposed post-hospitalization treatment plan in the least restrictive environment:

1. _____
2. _____
3. _____
4. _____

☐ Consumer Signature _____

☐ Refused to Sign

Case Number: _____
Name: _____

If this is a supplemental treatment plan, progress since the last report: _____
_____
_____
_____
_____
_____

Contact information for other providers and agencies involved in this person's treatment (please include provider name, agency/practice, address, city, zip, phone and fax number): _____
_____
_____
_____
_____

Continuity of Care

☐ The undersigned will **continue** to be the provider of record for this person and will continue to provide care until such time as the care has been transferred to another provider.

☐ The undersigned has made arrangements to **transfer** the care of this person to:

_____(Provider Named) at
_____(Address) _____(phone).
The first appointment is scheduled for _____(date) at _____(Time).

The undersigned agrees to continue caring for this person until care is initiated with the new provider and the new provider has filed an acceptance of transfer with the Board of Mental Health.

All providers agree to follow the expectations of the Board of Mental Health.

Physician Name: (print) _____

Title:_____ Phone: _____Fax: _____

Facility: _____

City, State, Zip: _____

Signature: _____Date: _____